Washington State Department of Social & Health Services
DDD Division of Developmental Disabilities

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)
FAMILY SUPPORT PROGRAM

SERVICE NEED LEVEL DETERMINATION AND WORKSHEET

(WAC 388-825-256)

CLIENT'S NAME	DDD NUMBER	DATE OF BIRTH	CASE MANAGER'S NAME

☐ **SERVICE NEED LEVEL (SNL) 1: CHECK ALL THAT APPLY**

☐ Person needs intensive (at least 10 days or 80 hours a month) in-home personal care-type services and is at risk of immediate out-of-home placement if these services are not provided. (Can be Family Support or other Department of Social and Health Services (DSHS) services, i.e., Medicaid Personal Care (MPC)).

Amount of service used during past three (3) months.*

MONTH	HOURS/DAYS USED	AMOUNT	MONTH	HOURS/DAYS USED	AMOUNT	MONTH	HOURS/DAYS USED	AMOUNT
		$			$			$

* Put in hours/days used. If any of this service was not funded by Family Support (e.g., Title XIX Personal Care, Division of Children and Family Services (DCFS) day care, insurance-paid nursing), explain in the area provided on the back of this form.

☐ SNL 1 Assessment attached for persons requiring intensive (at least 10 days or 80 hours a month) in-home personal care-type services AND is at risk of immediate out-of-home placement.

☐ **SERVICE NEED LEVEL (SNL) 2: CHECK ALL THAT APPLY**

☐ Person is at high risk of being placed out of home if requested services are not provided, AND

- ☐ Person is currently receiving Child Protective Services (CPS), Family Reconciliation Services (FRS), or DCFS Child Welfare Services or is receiving Adult Protective Services (APS).
  List type and date of services:
- ☐ Person has a medical problem that requires close and on-going monitoring and/or specialized care. **Give details in the area provided on back.** (See WAC 388-825-256(c).)
- ☐ Person has a current DSM Axis I mental health diagnosis of .
- ☐ Person has extreme behavior challenges resulting in significant health/safety issues for self/others. **Give details on back.**
- ☐ Person requires lifting, ☐ is 10-years or older, and/or ☐ weighs more than 40 pounds and requires "direct physical assistance" in at least three of these areas: ☐ Eating ☐ Dressing ☐ Bathing ☐ Toileting ☐ Mobility.
- ☐ Parent is currently eligible for DDD services.

Primary relative caregiver has:

- ☐ Documented mental health problem/substance abuse problem and is receiving counseling for this, or has recently received or applied for counseling for this problem. (Within the last 90 days)
- ☐ Documented physical/medical issue that interferes with care of person.

☐ **SERVICE NEED LEVEL (SNL) 3: CHECK ALL THAT APPLY**

☐ Without provision of services, person is at risk of being placed out of the home or of experiencing a significant deterioration in family functioning because of caregiver stress and/or client characteristics:

- ☐ Caregiver is experiencing ☐ acute/chronic stress; or has ☐ acute/chronic physical limitations; or has ☐ acute/chronic mental or emotional limitations.
- ☐ Person has ☐ medical problems requiring substantial extra care (give details on back); OR is ☐ three years of age or older and requires "direct physical assistance" above what is typical for a child his or her age in three or more of the following areas: ☐ Eating ☐ Dressing ☐ Bathing ☐ Toileting ☐ Mobility; OR has current behavioral episodes resulting in ☐ physical injury to self or others, ☐ substantial property damage, or ☐ chronic sleep pattern disturbances or ☐ chronic continuous screaming behavior. **Give details on back.**

☐ **SNL 4 FAMILY WOULD LIKE PERIODIC SERVICES TO RELIEVE OR PREVENT STRESS OR TO ENHANCE CURRENT FUNCTIONING.**

☐ There are no other private, local, state, or federal resources to help meet this family's needs.

Recommended Service Need Level: ☐ 1 ☐ 2 ☐ 3 ☐ 4	Approved Service Need Level: ☐ 1 ☐ 2 ☐ 3 ☐ 4
CASE MANAGER'S SIGNATURE DATE	REVIEW COMMITTEE'S SIGNATURE DATE
Recommended Service Need Level: ☐ 1 ☐ 2 ☐ 3 ☐ 4	Approved Service Need Level: ☐ 1 ☐ 2 ☐ 3 ☐ 4
CASE MANAGER'S SIGNATURE DATE	REVIEW COMMITTEE'S SIGNATURE DATE

PROVIDE DETAILS FOR THE ITEMS CHECKED ON THE REVERSE THAT SUPPORT YOUR RECOMMENDED SERVICE NEED LEVEL

Check all other DSHS services the client is using: ☐ MPC ☐ CHORE ☐ DCFS Services ☐ Other

Service period:

FAMILY REQUEST	CASE MANAGER'S TWELVE MONTHS RECOMMENDED	FOR REVIEW COMMITTEE USE ONLY		
TWELVE MONTHS		TWELVE MONTHS APPROVED	SERVICE NEED LEVEL (SNL)	TWELVE MONTHS SNL LID
$	$	$		$

CASE MANAGER'S SIGNATURE DATE

REVIEW COMMITTEE'S SIGNATURE/ETP APPROVAL DATE

COMMENTS

Service period:

FAMILY REQUEST	CASE MANAGER'S TWELVE MONTHS RECOMMENDED	FOR REVIEW COMMITTEE USE ONLY		
TWELVE MONTHS		TWELVE MONTHS APPROVED	SERVICE NEED LEVEL (SNL)	TWELVE MONTHS SNL LID
$	$	$		$

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$	$	$		$

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TWELVE MONTHS		TWELVE MONTHS APPROVED	SERVICE NEED LEVEL (SNL)	TWELVE MONTHS SNL LID
$	$	$		$

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COMMENTS